North Carolina Department of Health and Human Services
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Michael F. Easley, Governor

Dempsey Benton, Secretary

June 30, 2008

Teresa DeCaro, RN, M.S.
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations
Region IV
Atlanta Federal Center
61 Forsyth Street, SW Suite 4T20
Atlanta, GA 30303-8909

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2008-011

Dear Ms. DeCaro:

Enclosed is an amendment to North Carolina's State Plan Under Title XIX of the Social Security Act for the Medical Assistance Program. These changes affect Attachment 3.1-A.1, Pages 7c.3, 7c.3a, 7c.3b, 7c.3c, 7c.3d, 7c.3e, 7c.3f, 7c.and 7c.3g; Attachment 3.1-A.1, Pages 15a.2, 15a.2a, 15a.2b, 15a.2c, 15a.2d, 15a.2e, 15a.2f, and 15a.2g; Attachment 4.19-B, Section 13, Page 1, 2, 3, 4, 4a, 4b, 4c, 4d, 4e, 4f, 4g, 4h, 4i, and Attachment 4.19-B, Section 13, Page 5.

This state plan change modifies the coverage and reimbursement sections for Community Support Services. The coverage section was amended to 1) specify covered services, 2) add specific staffing requirements and delineate provision of services, 3) include admission and continued stay criteria, 4) include provisions for utilization management, and 5) clarify documentation requirements. Amendments to the reimbursement section will establish a tiered rate system for the service of Community Support Individual (codes: H0036HA and H0036HB). North Carolina is moving from a single rate for the service to a rate methodology that recognizes the different provider qualifications levels (e.g. Paraprofessional, Associate Professional, Qualified Professional-Unlicensed, and Qualified Professional- Licensed). The reimbursement methodology used to establish the rates utilizes cost modeling which is based upon input from providers and compared to national data. The cost model recognizes direct care service costs for staff salaries and related fringe benefits, program-related expenses, supervision costs, provider overhead, and productivity. Payment for Community Support Individual continues to be based on a 15 minute unit of service. The reimbursement rate for Community Support Group has been modified in accordance with the change for Community Support Individual.

The proposed effective date of this Plan amendment is October 1, 2008. Documentation of public notice provided will be forwarded upon receipt of the affidavit.

Your approval of this amendment is requested.

Sincerely,

Dempsey Benton

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **08-011**

2. STATE: **NC**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2008

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
CFR 440.130(d)

7. FEDERAL BUDGET IMPACT:
a. **FFY 2008-09 ($92,017,020)**
b. **FFY 2010-11 ($118,237,532)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A.1, Pages7c.3, 7c.3a, 7c.3b, 7c.3c, 7c.3d, 7c.3e, 7c.3f, 7c.3g. Attachment 3.1-A.1, Pages 15a.2, 15a.2a, 15a.2b, 15a.2c, 15a.2d, 15a.2e, 15a.2f, 15a.2g. Attachment 4.19-B, Section 13, Page 1, 2, 3, 4, 4a, 4b, 4c, 4d, 4e, 4f, 4g, 4h, 4i, and Attachment 4.19-B, Section 13, Page 5.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment3.1-A.1, Page 7c.3, Attachment 3.1-A.1, Page 15a.2, Attachment 4.19-B, Section 13, Page 1, Attachment 4.19-B, Section 13, Page 4 and Attachment 4.19-B, Section 13, Page 5

10. SUBJECT OF AMENDMENT:

This state plan amendment is for Community Support Services for Individuals and for Groups.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dempsey Benton

14. TITLE:
Secretary

15. DATE SUBMITTED:
June 30, 2008

16. RETURN TO:

Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

Non-Institutional Payment Team (NIPT) Standard Funding Questions:

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

- **No portion of the service rates paid is returned to the state**

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

- **The state share is from appropriation from the legislature to the Medicaid agency.**

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

- **No supplemental or enhanced payments are made for any of these services.**

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

- **Not applicable to these services**

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

- **No, rates are set to reimburse providers on a fair and reasonable basis.**

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

(c) Community Supports Child (CS) (CFR 42 430.130(d))
Community Support services are community-based rehabilitative services and interventions necessary to treat children and adolescents 20 years old or younger to achieve their mental health and/or substance abuse recovery goals and to assist parents and other caregivers in helping children and adolescents build resiliency. These medically necessary services directly address the recipient's diagnostic and clinical needs, evidenced by the presence of a diagnosable mental, behavioral, and/or emotional disturbance (as defined by the DSM-IV-TR and its successors), with symptoms and effects documented in a comprehensive clinical assessment and a Person Centered Plan.

These services are designed to:

- enhance skills necessary to address the complex mental health and/or substance abuse symptoms of children and adolescents who have significant functional deficits due to these disorders, to promote symptom reduction and improve functioning in their daily environments;
- assist the child/adolescent and family in acquiring the necessary skills for reaching recovery from mental health and/or substance abuse disorders, for self management of symptoms and for addressing vocational, housing, and educational needs;
- link recipients to, and coordinate, necessary services to promote clinical stability and meet the mental health/substance abuse treatment, social, and other treatment support needs while supporting the emotional and functional growth and development of the child; and
- monitor and evaluate the effectiveness of delivery of all services and supports identified in the Person Centered Plan.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

The rehabilitative service activities of Community Support consist of a variety of interventions that must directly relate to the recipient's diagnostic and clinical needs as reflected in a comprehensive clinical assessment and goals outlined in the Person Centered Plan.

These shall include the following, as clinically indicated:

- Facilitation of the Person Centered Planning process with the Child and Family Team which includes the child, parent or legal guardian, and others identified as important in the recipient's life (e.g., family, friends, providers);
- Identification of strengths that will aid the child and family in the child's recovery, as well as the identification of barriers that impede the development of skills necessary for functioning in the community that will be addressed in the Person Centered Plan;
- Initial development, implementation, and ongoing revision of Person Centered Plan; Monitoring the implementation of the Person Centered Plan, including involvement of other medical and non-medical providers, the child and the family, and other natural and community supports;
- Individual (1:1) interventions with the child or adolescent, unless a group intervention is deemed more efficacious;
- Therapeutic interventions that directly increase the acquisition of skills needed to accomplish the goals of the Person Centered Plan;
- Identification and self-management of symptoms;
- Identification and self-management of triggers and cues (early warning signs);
- Direct preventive and therapeutic interventions, associated with the mental health or substance abuse diagnosis that will assist with skill building related to goals in the Person-Centered Plan as related to the mental health or substance abuse diagnosis and symptoms;
- Direct interventions in escalating situations to prevent crisis (including identifying cues and triggers);
- Assistance for the youth and family in implementing preventive and therapeutic interventions outlined in the Person-Centered Plan (including the crisis plan);
- Response to crisis 24/7/365 as indicated in the recipient's crisis plan and participation in debriefing activities to revise the crisis plan as needed;
- Relapse prevention and disease management strategies;
- Psychoeducation and training of family, unpaid caregivers, and others who have a legitimate role in addressing the needs identified in the Person Centered Plan;
- Coordination and oversight of initial and ongoing assessment activities;
- Ensuring linkage to the most clinically appropriate and effective services;
- Facilitation of the Person Centered Planning process with the Child and Family Team which includes the recipient, legally responsible person, and others identified as important in the recipient's life (e.g., family, friends, providers);
- Initial development, implementation, and ongoing revision of Person Centered Plan; and
- Monitoring the implementation of the Person Centered Plan, including involvement of other medical and non-medical providers, the consumer, and natural and community supports

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

The service must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner. The providers of this service will also serve as a "first responder" in a crisis situation. Clinical criteria (medical necessity criteria for admission and continued services) are presented below:

Admission Criteria

The recipient is eligible for this service when:

A. significant impairment is documented in at least two of the life domains related to the recipient's diagnosis, that impede the use of the skills necessary for independent functioning in the community. These life domains are as follows: emotional, social, safety, medical/health, educational/vocational, and legal.

B. there is an Axis I or II MH/SA diagnosis (as defined by the DSM-IV-TR or its successors), other than a sole diagnosis of Developmental Disability

C. for recipients with a substance abuse diagnosis, American Society for Addiction Medicine (ASAM) criteria is met.

D. the recipient is experiencing functional impairments in at least two of the following areas as evidenced by documentation of symptoms:
   1. is previously or imminently at risk for institutionalization, hospitalization, or placement outside the recipient's natural living environment;
   2. is receiving or needs crisis intervention services or Intensive In-Home services;
   3. has unmet identified needs related to MH/SA diagnosis as reported from multiple agencies, needs advocacy, and service coordination as defined by the Child and Family Team;
   4. is abused or neglected as substantiated by DSS, or is found in need of services by DSS, or meets dependency as defined by DSS criteria (GS 7B101);
   5. exhibits intense verbal aggression, as well as limited physical aggression, to self or others, due to symptoms associated with diagnosis, which is sufficient to create functional problems in the home, community, school, job, etc.; or
   6. is in active recovery from substance abuse or dependency and is in need of continuing relapse prevention support

E. There is no evidence to support that alternative interventions would be equally or more effective based on North Carolina community practice standards (e.g., Best Practice Guidelines per the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine) as available or based on established utilization review criteria established by the NC Department of Health and Human Services.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the Community Support service goals in the recipient's Person Centered Plan; or the recipient continues to be at risk for relapse based on current clinical assessment, history, and the tenuous nature of the functional gains or continues to meet the utilization criteria established by the NC Department of Health and Human Services;

One of the following applies:

A. Recipient has achieved current Community Support goals in the Person Centered Plan and additional goals are indicated as evidenced by documented symptoms.
B. Recipient is making satisfactory progress toward meeting Community Support goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the Person Centered Plan.
C. Recipient is making some progress, but the Community Support interventions in the Person Centered Plan need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
D. Recipient fails to make progress and/or demonstrates regression in meeting the Community Support goals through the strategies outlined in the Person Centered Plan. The recipient's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, with treatment recommendations revised based on findings.

Staffing Requirements

The service must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner. The providers of this service will also serve as a "first responder" in a crisis situation. The service will be provided by an endorsed community support agency. The endorsement process includes Community Support service specific checklist, and adherence to the following:

- Rules for MH/DD/SA Facilities and Services,
- Confidentiality Rules,
- Client Rights Rules in Community MH/DD/SA Services,
- Records Management and Documentation Manual for Providers of Publicly Funded MH/DD/SA Services, CAP-MR/DD Services and LMEs and,
- Implementation Updates to Rules, revisions and policy guidance.

Providers enrolled in Community Support must be nationally accredited by one of the accrediting bodies approved by DHHS within one year of Medicaid enrollment.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

The agency must have a full time licensed clinical professional on staff. The community based service is provided by qualified professionals, paraprofessionals and associate professionals, who must have 20 hours of training specific to the requirements of the service definition within the first 90 days of employment.

In addition, persons employed or contracted must meet the requirements specified (10A NCAC 27G.0104) for Qualified Professional (QP), Associate Professional (AP), and Paraprofessional status, and who have the knowledge, skills, and abilities required by the population and age to be served, may deliver Community Support. Associate Professionals and Paraprofessionals will deliver Community Support services to address directly the recipient's diagnostic and clinical needs under the direction of the Qualified Professional.

All Associate Professionals and Paraprofessionals providing Community Support must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline. These staff must also demonstrate compliance with the identified competencies in the areas of participating empowerment, communication, clinical knowledge, community and service networking, implementation of person centered services, advocacy, crisis prevention and intervention and documentation. Non Post-Graduate degreed Qualified Professionals must be supervised by a Master's Level Qualified Professional, preferably Licensed.

The Qualified Professional has sole responsibility for:

- Facilitation of the Person Centered Planning process, through the Child and Family Team, which includes the active involvement of the child/adolescent, family members, legally responsible person, and others identified as important in the recipient's life (e.g., friends, providers);
- Initial development, implementation, and ongoing revision of Person Centered Plan;
- Monitoring and evaluating the effectiveness of interventions as evidenced by symptom reduction and progress toward goals identified in the Person Centered Plan;
- Coordination and oversight of initial and ongoing assessment activities; and
- Ensuring linkage to the most clinically appropriate and effective services

The Qualified Professional may also perform the activities, functions, and interventions of the Community Support service definition included in the chart below. A minimum of 25% or an amount determined by the NC legislature, not less than 25%, must be delivered by a qualified professional.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

The following chart sets forth the activities included in this service definition. These activities reflect the appropriate scope of practice for the Community Support staff identified below.

Community Support Services	
Professional Services May be provided by the Qualified Professional.	Skill Based Interventions May be provided by the Qualified Professional, the Associate Professional (under the supervision, direction, and oversight of the Qualified Professional), or the Paraprofessional (under the supervision, direction, and oversight of the Qualified Professional)
• Therapeutic interventions that directly increase the acquisition of skills needed to accomplish the goals of the Person Centered Plan • Psychoeducation regarding the identification and self-management of prescribed medication regimen, with documented communication to prescribing practitioner(s) • Direct preventive and therapeutic interventions that will assist with skill building related to goals in the Person-Centered Plan • Direct interventions in escalating situations to prevent crisis (including identifying cues and triggers) • Assistance for the child/adolescent and family in implementing preventive and therapeutic interventions outlined in the Person-Centered Plan (including the crisis plan) • Response to crisis 24/7/365 as indicated in the recipient's crisis plan and participation in debriefing activities to revise the crisis plan as needed • Relapse prevention and disease management strategies • Psychoeducation of family, unpaid caregivers, and others who have a legitimate role in addressing the needs identified in the Person Centered Plan	• Provision of skill-building interventions to rehabilitate skills negatively affected by their mental health and/or substance abuse diagnosis o Functional skills o Socialization, relational, and coping skills o Self-management of symptoms o Behavior and anger management skills • Implementation of preventive and therapeutic interventions that will facilitate skill building • Identification and self-management of symptoms • Identification and self-management of triggers and cues (early warning signs) • Input into the Person Centered Plan modifications

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

Professional Services	School Based Interventions
• Participation in ongoing assessment activities (observation and ongoing activities to address progress or lack thereof) of this service • Participation in the initial development and ongoing revision of Person Centered Plan through ongoing clinical involvement in the Child and Family Team. • Assessing, documenting, and communicating the status of the recipient's progress and the effectiveness of the strategies and interventions of this service to the Child and Family Team as outlined in the Person Centered Plan. • Supportive counseling to address the diagnostic and clinical needs of the recipient • Supervision by the Qualified Professional of Community Support activities provided by Associate and Paraprofessional staff. The Qualified Professional is responsible for the all the activities and interventions of this service.	

Family members or legally responsible persons of the recipient may not provide these services for reimbursement.

Utilization management:

Services are based upon a finding of medical necessity, must be directly related to the child or adolescent's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the individual's Person Centered Plan. Medical necessity is determined by North Carolina community practice standards, criteria established by the NC Department of Health and Human Services and as verified by the independent Medicaid utilization management vendor. Prior authorization is required for all community support services. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

Units are billed in 15-minute increments and must include the modifier to denote level of staff providing the service

Service Exclusions, Limitations

A child or adolescent may receive Community Support services from only one Community Support provider organization at a time.

Documentation Requirements

The minimum standard is a daily full service note, including crisis response activities written and signed by the person who provided the service that includes:

- Recipient's name
- Medicaid identification number
- Service provided (e.g., Community Support–Individual or Community Support–Group)
- Date of service
- Place of service
- Type of contact (face-to-face, phone call, collateral)
- Purpose of the contact
- Description of the provider's interventions
- Amount of time spent performing the interventions
- Description of the effectiveness of the interventions
- Signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature)
- The documentation must be in compliance with "Records Management and Documentation Manual for Providers of Publicly Funded MH/DD/SA Services, CAP-MR/DD Services and LMEs."

There are limitations indicated to prevent this service from being provided while a child is an inpatient or receiving residential treatment, or an intensive in-home service, Multi-Systemic Therapy or intensive substance abuse service with the exception of 8 units per months in the case management component of the service.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

(iii) Community Support - (adults) (CS)

Community Support Services consist of mental health and substance abuse community based, rehabilitation services and interventions necessary for and individual to achieve rehabilitative, sobriety, and recovery goals. This medically necessary service directly addresses the recipient's diagnostic and clinical needs that are evidenced by the presence of a diagnosable mental illness and/or substance related disorder (as defined by the DSM-IV-TR and its successors), with symptoms and effects documented in a comprehensive clinical assessment and the Person Centered Plan.

The services are designed to:

- Enhance skills to address the complex mental health and/or substance abuse symptoms of adults who have significant functional deficits in order to promote symptom reduction;
- Assist recipients in acquiring mental health and/or substance abuse recovery skills necessary for self management and to address successfully vocational, housing, and educational needs.
- Link recipients to, and coordinate, necessary services to promote clinical stability and to meet an individual's mental health/substance abuse treatment, social, and other treatment support needs;
- Monitor and evaluate the effectiveness of delivery of all services and supports identified in the Person Centered Plan.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

The rehabilitative service activities of Community Support consist of a variety of interventions that must directly relate to the recipient's diagnostic and clinical needs as reflected in a comprehensive clinical assessment and goals outlined in the Person Centered Plan.

These shall include the following, as clinically indicated:

- Identification of strengths that will aid the individual in his or her recovery, as well as the identification of barriers that impede the development of skills necessary for independent functioning in the community.
- Individual (1:1)interventions with the recipient, unless a group intervention is deemed more efficacious.
- Therapeutic interventions that directly increase the acquisition of skills needed to accomplish the goals of the Person Centered Plan.
- Monitoring and evaluating the effectiveness of interventions as evidenced by symptom reduction and progress toward goals identified in the Person Centered Plan.
- Psychoeducation regarding the identification and self-management of prescribed medication regimen, with documented communication to prescribing practitioner(s).
- Identification and self-management of symptoms.
- Identification and self-management of triggers and cues (early warning signs).
- Direct preventive and therapeutic interventions associated with the MH/SA diagnosis that will assist with skill building related to goals in the Person-Centered Plan.
- Direct interventions in escalating situations to prevent crisis (including identifying cues and triggers).
- Assistance for the recipient and natural supports in implementing preventive and therapeutic interventions outlined in the Person-Centered Plan (including the crisis plan).
- Response to crisis 24/7/365 as indicated in the recipient's crisis plan and participation in debriefing activities to revise the crisis plan as needed.
- Relapse prevention and disease management strategies.
- Psychoeducation and training of family, unpaid caregivers, and others who have a legitimate role in addressing the needs identified in the Person Centered Plan.
- Coordination and oversight of initial and ongoing assessment activities.
- Ensuring linkage to the most clinically appropriate and effective services.
- Facilitation of the Person Centered Planning process which includes the active involvement of the recipient and people identified as important in the recipient's life (e.g., family, friends, and providers).
- Initial development and ongoing revision of Person Centered Plan.
- Monitoring the implementation of the Person Centered Plan, including involvement of other medical and non-medical providers, the consumer, and natural and community supports.
- Effective coordination of clinical services, natural and community supports for the recipient and his or her family.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

Entrance Criteria

The recipient is eligible for this service when:

A. Significant impairment is documented in at least two of the life domains related to the recipient's diagnosis that impedes the use of the skills necessary for independent functioning in the community. These life domains are as follows: emotional, social, safety, housing, medical/health, and legal.

B. There is an Axis I or II MH/SA diagnosis as defined by the DSM-IV-TR or its successors, other than a sole diagnosis of Developmental Disability.

C. For recipients with a substance abuse diagnosis, American Society for Addiction Medicine (ASAM) criteria is met.

D. The recipient is experiencing functional impairments in at least two of the following criteria as evidenced by documentation of symptoms:
    1. is at risk for institutionalization, hospitalization, or is placed outside the natural living environment;
    2. is receiving or needs crisis intervention services;
    3. has unmet identified needs, related to the MH/SA diagnosis, for services from multiple agencies related to the life domains and needs advocacy and service coordination;
    4. is abused or neglected as substantiated by DSS, or has established dependency as defined by DSS criteria;
    5. exhibits intense verbal aggression, as well as limited physical aggression, to self or others, due to symptoms associated with diagnosis, that is sufficient to create functional problems in the home, community, school, job, etc. and/or;
    6. is in active recovery from substance abuse or dependency and is in need of continuing relapse prevention support.

E. There is no evidence to support that alternative interventions would be equally or more effective based on North Carolina community practice standards (e.g., American Society for Addiction Medicine, American Psychiatric Association) as available or established utilization review criteria as established by the NC Department of Health and Human Services

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the Community Support service goals in the recipient's Person Centered Plan; or the recipient continues to be at risk for relapse based on current clinical assessment, history, and the tenuous nature of the functional gains or continues to meet the utilization criteria established by the NC Department of Health and Human Services;

One of the following applies:

A. Recipient has achieved current Community Support goals in the Person Centered Plan and additional goals are indicated as evidenced by documented symptoms.
B. Recipient is making satisfactory progress toward meeting Community Support goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the Person Centered Plan.
C. Recipient is making some progress, but the Community Support interventions in the Person Centered Plan need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
D. Recipient fails to make progress and/or demonstrates regression in meeting the Community Support goals through the strategies outlined in the Person Centered Plan. The recipient's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, with treatment recommendations revised based on findings.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

Staffing Requirements:

The agency must have a full time licensed clinical professional on staff. The community based service is provided by qualified professionals, paraprofessionals and associate professionals, who must have 20 hours of training specific to the requirements of the service definition within the first 90 days of employment.

The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner. The providers of this service will also serve as a "first responder" in a crisis situation. The service will be provided by an endorsed community support agency. The endorsement process includes service specific checklist, adherence to MH/DD/SA core rules, client rights and Service records manual. The agency must have a full time licensed clinical professional all staff. The community based service is provided by qualified professionals, paraprofessionals and associate, who must have 20 hours of training specific to the requirements of the service definition within the first 90 days of employment.

In addition, persons who meet the requirements specified (10A NCAC 27G .0104) for Qualified Professional (QP) Associate Professional (AP), or Paraprofessional status, and who have the knowledge, skills, and abilities required by the population and age to be served, may deliver Community Support. Qualified Professionals shall develop and coordinate the Person Centered Plan. Associate Professionals and Paraprofessionals may deliver Community Support services to directly address the recipient's diagnostic and clinical needs under the direction of a Qualified Professional.

All Associate Professionals and Paraprofessionals providing Community Support must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G .0204 and according to licensure or certification requirements of the appropriate discipline. These staff must also demonstrate compliance to the identified staff competencies. Non Post-Graduate degreed Qualified Professionals must be supervised by a Master's Level Qualified Professional, preferably Licensed.

The Qualified Professional has sole responsibility for:

- Facilitation of the Person Centered Planning process, which includes the active involvement of the recipient and others identified as important in the recipient's life (e.g., family, friends, providers)
- Initial development, implementation, and ongoing revision of Person Centered Plan
- Monitoring and evaluating the effectiveness of interventions as evidenced by symptom reduction and progress toward goals identified in the Person Centered Plan.
- Coordination and oversight of initial and ongoing assessment activities
- Ensuring linkage to the most clinically appropriate and effective services

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

The Qualified Professional may also perform the activities, functions, and interventions of the Community Support service definition included in the chart below. A minimum of 25% or an amount determined by the NC legislature, not less than 25%, must be delivered by a qualified professional.

The following chart sets forth the additional activities included in this service definition. These activities reflect the appropriate scope of practice for the Community Support staff identified below.

Community Support Services	
Professional Services	Skill Based Interventions
May be provided by the Qualified Professional. • Therapeutic interventions that directly increase the acquisition of skills needed to accomplish the goals of the Person Centered Plan • Psychoeducation regarding the identification and self-management of prescribed medication regimen, with documented communication to prescribing practitioner(s) • Direct preventive and therapeutic interventions that will assist with skill building related to goals in the Person-Centered Plan • Direct interventions in escalating situations to prevent crisis (including identifying cues and triggers) • Assistance for the recipient and natural supports in implementing preventive and therapeutic interventions outlined in the Person-Centered Plan (including the crisis plan) • Response to crisis 24/7/365 as indicated in the recipient's crisis plan and participation in debriefing activities to revise the crisis plan as needed	(May be provided by the Qualified Professional, the Associate Professional (under the supervision, direction, and oversight of the Qualified Professional), or the Paraprofessional (under the supervision, direction, and oversight of the Qualified Professional))

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

• Relapse prevention and disease management strategies • Psychoeducation of family, unpaid caregivers, and others who have a legitimate role in addressing the needs identified in the Person Centered Plan • Participation in ongoing assessment activities (observation and ongoing activities to address progress or lack thereof) of this service • Participation in the initial development and ongoing revision of Person Centered Plan. • Assessing and documenting the status of the recipient's progress and the effectiveness of the strategies and interventions of this service as outlined in the Person Centered Plan. • Supportive counseling to address the diagnostic and clinical needs of the recipient • Supervision by the Qualified Professional of Community Support activities provided by Associate and Paraprofessional staff. The Qualified Professional is responsible for the all the activities and interventions of this service	

Family members or legally responsible persons of the recipient may not provide these services for reimbursement.

There are systems limitations indicated to prevent this service from being provided while an adult is an inpatient or receiving residential treatment, or an intensive substance abuse service.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services *(continued)*
Description of Services

Utilization Management

Services are based upon a finding of medical necessity, must be directly related to the recipient's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the individual's Person Centered Plan. Medical necessity is determined by North Carolina community practice standards, criteria established by the NC Department of Health and Human Services and as verified by independent Medicaid utilization management vendor. Prior authorization is required for all community support.

Units are billed in 15-minute increments, with the required modifier designating the level of the staff providing the service.

Service Exclusions and Limitations

An adult recipient may not receive more than 780 units in any one 90-day period.

An individual may receive Community Support services from only one Community Support provider organization at a time.

Documentation Requirements
The minimum standard is a daily full service note including crisis response activities written and signed by the person who provided the service that includes:

- Recipient's name
- Medicaid identification number
- Service provided (e.g., Community Support – Individual or Group)
- Date of service
- Place of service
- Type of contact (face-to-face, phone call, collateral)
- Purpose of the contact
- Description of the provider's interventions
- Amount of time spent performing the interventions
- Description of the effectiveness of the interventions
- Signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature)
- The documentation must be in compliance with "Records Management and Documentation Manual for Providers of Publicly Funded MH/DD/SA Services, CAP-MR/DD Services and LMEs."

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13. OTHER DIAGNOSTIC SCREENING PREVENTIVE AND REHABILITATIVE SERVICES

A. Payments for other diagnostic screening, preventive and rehabilitative services provided by qualified providers are based on rates established by the Division of Medical Assistance for each type of mental health covered service. -Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers with the fee published in the fee schedule and any annual/periodic adjustments to the fee schedule are published on the NC Division of Medical Assistance Web site http://www.ncdhhs.gov/dma/fee/fee.htm.

B. Beginning July 1, 2004, the Division will establish prospective rates with all providers of mental health services. The initial prospective rates for HCSPCS Level II code (non-CPT code) mental health services will be established primarily based on 2002 cost report information, recognizing a 13% reduction in these rates to eliminate administrative costs included in mental health service rates in effect prior to July, 1, 2004. In addition, these HCSPCS Level II (non-CPT) code prospective rates for selected services will include increases for two years of inflation utilizing the GNP implicit price deflator. Inflationary increases will be made to these selected services to ensure sufficient providers of services are available to prevent accesses to care issues and to ensure that rates are reasonable.

C. Also, effective July 1, 2004, HCSPCS Level II (CPT code) mental health services will follow guidelines established for physician fee schedule services (4.19B, Section 5 Page 1). Rates can be adjusted to other than a physician fee schedule rate when it is determined that an access to care issue exists for a particular service. If services are provided by non-physician practitioners, rates will be reduced to a percentage of the physician fee schedule as outlined at 4.19B, Section 6. HCSPCS Level II (CPT code) rate services will be adjusted annually consistent with changes in the physician fee schedule rates.

D. With the implementation of the new enhanced services, October 1, 2005, as with well as any other new services which might be implemented subsequently, the Division will utilize various methodologies to determine appropriate reimbursement rates. Such methodologies will include cost modeling, an examination of what other states reimburse for identical or similar services or adjustment of current cost data to take into account the application of best practices as provided for in the new/revised mental health services.

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13. OTHER DIAGNOSTIC SCREENING PREVENTIVE AND REHABILITATIVE SERVICES-CONTINUED

(E) Annual cost reporting will continue to be required of providers who provide mental health services subsequent to July 1, 2005 and will be used to ensure the rates for new as well as existing services continue to be reasonable and fair. Beginning with SFY 2010 rates for enhanced mental health services will be adjusted based on the last reviewed mental health cost reports. Rates will not exceed the statewide median for the respective service.

(F) Reasonable costs are determined by the Division of Medical Assistance based upon the standards set in 2 CFR 225 and the CMS Provider Reimbursement Manual. Notwithstanding any other provision, if specified these rates will be adjusted as shown on Supplement 1 to the 4.19-B section of the state plan.

(G) The Division's determination of reasonable cost shall take into consideration only the cost of service related to providing Medicaid covered services. Rates shall be established at a level no greater than reasonable cost. Any costs related to non-Medicaid covered services shall be excluded from the rate determination process.

(H) Prospective mental health service rates will not be cost settled.

(Note: The Division of Medical Assistance will complete cost settlement on the FY 2003 and FY 2004 expenditures in accordance with the State Plan in effect during those years. Settlement of FY 2003 and FY 2004 expenditures will be to a statewide average unit cost for each type of service and will be completed within six months of all the completed reports being received by the Division of Medical Assistance, but no later than June 30, 2006.)

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(I). The services covered under this section are included under Attachment 3.1-A.1 of the state plan. These services are reimbursed on the basis of either a fee schedule or a per diem. Per Diem reimbursement methodologies for mental health bundled services are as detailed below. There are no payments for room, board or other administrative costs in inpatient psychiatric facilities, including facilities serving children under 21; reimbursement is for treatment costs only. No payments will be made to residents of IMDs, except for services provided to children under the age of 21 in inpatient psychiatric facilities meeting the requirements of 42 Code of Federal Regulations Part 441, Subpart D, and Part 483, Subpart G.

1. Substance Abuse Comprehensive Outpatient Treatment program (SACOT) (Adult – H2035)

The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. The rate also includes salaries and fringe benefits for direct care staff and professional staff. Comprehensive Outpatient Treatment Program (SACOT) is reimbursed on a per hour basis with a minimum of 4 hours per day necessary to generate a billable event. The reimbursement rate is established by augmenting the existing service, Intensive Outpatient Services (IOP) (for outpatient therapy (individual/group/family) as provided by licensed or certified mental health practitioners) rate by 33% to reflect more intensive treatment. The new rate consists of a weighted average of individual/ group/family therapy plus 2 hours of community support (based upon current utilization of case management) per week. For IOP, the client to staff ratios is lower and the number of hours of service is higher. For SACOT, the recipient must attend for at least 4 hours a day and the program must be open at least 5 days a week, with client to Qualified Professional (QP) ratio of at most 10:1. The new rate consists of a weighted average of individual/ group/family therapy plus 2 hours of community support (based upon the current utilization of case management at the time the rates were calculated) per week. The rate also includes salaries and fringe benefits for direct care staff and professional staff. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (xii).

2. Intensive In-Home Services (Child – H2022)

The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. The initial rate set for the reimbursement of this service is the established rate for Intensive In-Home Services as reimbursed by North Carolina's SCHIP (Health Choice) program.

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The establishment of the reimbursement rate requires a minimum of two hours per day of outpatient therapy services (individual, family, case management) per service incident and is billed as a per diem rate. This service is provided in accordance with Attachment 3.1-A.1, paragraph 4.b.(8)(g).

3. Medically Monitored or Alcohol Drug Addiction Treatment Center Detoxification/ Crisis Stabilization (Adult – H2036)

   Upon request, an individual facility interim rate will be determined as follows:

   Reimbursement rates are determined on the basis of provider specific pro forma cost information. Providers submit cost templates and a reimbursement rate is established utilizing cost modeling. The cost model is based on agency estimates. The residential facility cost model recognizes direct care service costs for staff salaries and fringe benefits and includes qualified, associate and paraprofessionals. Other direct service costs recognized include accreditation, communications, training, and travel costs. Facility overhead costs are recognized at 11% of total direct care service costs. A calculated per diem is determined by dividing total estimated days of service provided to recipients. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (xvii).

4. Substance Abuse Intensive Outpatient Program (Child and Adult – H0015)

   The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. This per diem reimbursement rate is established by augmenting an existing service, Intensive Outpatient Services (IOP) rate by 26% to reflect more intensive treatment. The IOP service for outpatient therapy (individual/group/family) provided by licensed or certified mental health practitioners has an existing rate that was based on the state wide average cost per unit derived from the 2002 Mental Health Cost Finding reports submitted the Area Mental Health programs with the 13% overhead costs removed (this over head cost was allowed under the AMH programs). The rate for the enhanced service consists of a weighted average of individual/ group/family therapy plus 1.5 hours of community support (based upon current utilization of case management) per week). The rate also includes salaries and fringe benefits for direct care staff and professional staff. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (xi).

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5. Substance Abuse Non-medical Community Residential Treatment – (Adult – H0012HB)

The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. The reimbursement rate is a per diem rate based on a two-tiered level of treatment utilizing the SACOT rate discussed in paragraph 1) above. Though the service recognizes two levels of treatment such that a more intense level of treatment is provided for the first 3 months and lower level of treatment is provided for the next 6 months, one rate was established to produce incentive to stay the full course of treatment. The SACOT rate component is modified to recognize five days of treatment per week with an additional hour of case management and an additional hour of community support requirements. Rates include costs for salaries and fringe benefits of direct care service workers comprised of Substance Abuse (SA) – qualified, licensed and certified professionals (Certified Clinical Supervisor (CCS), Certified Clinical Addition Specialist (CCAS) and Certified Substance Abuse Counselor (CSAC)) who lead the group and individual counseling with support from associate professionals and paraprofessionals. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (xiii).

6. Substance Abuse Medically Monitored Community Residential Treatment (Adult – H0013)

The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. The reimbursement rate is a per diem rate based on a two-tiered level of treatment utilizing the SACOT rate as discussed above in paragraph 1). Though the service recognizes two levels of treatment such that a more intense level of treatment is provided for the first 3 months and lower level of treatment is provided for the next 6 months, one rate was established to produce incentive to stay the full course of treatment. The SACOT rate component is modified to recognize five days of treatment per week with two hours of additional case management. The CBS (community based services) is removed. Rates include costs for salaries and fringe benefits of direct care service workers comprised of SA – qualified, licensed and certified professionals (Certified Clinical Supervisor (CCS), Certified Clinical Addition Specialist (CCAS) and Certified Substance Abuse Counselor (CSAC)) who lead the group and individual counseling with support from associate professionals and paraprofessionals and includes medical personnel (physicians, registered nurses, licensed practical nurses) and an extra certified clinical addiction specialists to cover the night shift. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (xiv).

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7. Non Hospital Medical Detoxification (Adult – H0010)

The rate for this enhanced service was set as of June 1, 2006 and is effective for services on or after that date. The per diem reimbursement rate is established utilizing cost modeling. The cost model is based on agency estimates and is confirmed by input from at least three qualified providers and recognizes direct care service costs for staff salaries and fringe benefits. Direct care staff includes registered nurses, health care technicians, substance abuse counselors as well as a physician. Facility overhead costs are calculated at 11% of total annual salaries and fringe benefits of direct care service staff. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (xvi).

8. Partial Hospital (Child and Adult – H0035)

The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. Reimbursement rate for this existing service is based on state fiscal year 2002 cost findings submitted by mental health area programs. The per diem rate established by the cost report data was reduced by 13% to remove overhead costs included in area program cost findings. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (v).

9. Assertive Community Treatment Team (ACTT) (Adult – H0040)

The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. The starting rate of $206.98 is the rate developed from the 2002 AMH Cost Finding report, inflated forward three years. The reimbursement rate is based on modifying an existing ACTT service to make it conform to the best practice model as approved by CMS. The base rate of $206.98 was increased 20% based on the staffing ratio changes required by the new enhanced service. It requires at least four face to face contacts per month by team members. The model includes at a minimum; a qualified professional (QP), a nurse (RN), a physician (at least .25 FTEs per 50 clients), and paraprofessional staff who provide available 24 hour coverage. The additional staffing requirements were added. The new service model team members include an additional nurse (RN), a substance abuse specialist (CCS, LCAS, or CSAC), an administrative assistant/secretary, three additional QPs and increases physician hours by thirty percent. Rates include costs for salaries and fringe benefits of qualified professionals (QP), nurses (RN), physician, substance abuse specialists, administrative assistant/secretary and paraprofessional staff. The rate for this service is based on the salary and benefits of the required FTEs by type of professional, assuming each team sees roughly 100 clients / per month and each client at least once a week. The rate is calculated as a monthly rate then divided by 4 (to insure the four face to face contacts) to establish the per event amount billable by the quarter month. The provider will not be paid for more than four contacts (events) per month, although the service requires the provider to provide all service necessary. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (viii).

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10. Diagnostic Assessment (Child and Adult - T1023)

The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. North Carolina contracted with Technical Assistance Collaborative, Inc. (TAC) to develop and recommend a rate for Diagnostic Assessment (MH/SA) T1023. TAC used National rate data to determine an appropriate rate for this service. The rate information from each state was reviewed for a variety of factors to best match the type of services with those proposed by NC. The services were grouped into the levels of care and service types from NC in order for comparison. Analysis and groupings were based on:

- Comparability to proposed NC Services,
- Credentials and number of staff providing the services,
- Other program specific requirements such as 24/7 availability, licensure requirements, etc.

Once the comparable and current rates were identified, an adjustment factor was developed for each state to smooth the economic difference between NC and the other states. Factors used were:

- Cost of Living
- Median household income
- Community/social service salary levels

The inflation or deflation factors were then averaged to obtain a single factor to apply to the rate from each geographic area to obtain the NC comparable rate.

Additionally, the rate for Diagnostic Assessment was adjusted to estimate the potential impact of the FY02 cost settlement by applying the percentage change from the FY01 settlement. This service is billed per event. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (ii).

11. Opioid Treatment (Adult – H0020)

The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. The rate was based on the existing service H0020 Methadone Administration. The cost per unit is based on the 2001 Mental Health Cost Finding reports submitted by the Area Mental Health (AMH) programs. The 13% administrative overhead cost included in the Area Mental Health programs rate was removed. No inflation cost was added. This service is billed per event. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (x).

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The following services are billed in per 15 minute or per hour increments. Reimbursement will be on a fee for service basis. These services will be provided by direct enrolled providers.

1. Psychosocial Rehabilitation (Adult – H2017)

   The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. The rate for H2017 was developed from existing service Y2313 using the 2002 AMH Cost Finding report minus the 13% administrative overhead cost previously allowed. Three years inflation is added. This service is billed in per 15 minute increments where one unit equals 15 minutes. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (iv).

   The rate for enhanced service Psychosocial Rehabilitation (PSR) (Adult – H2017) was changed effective with dates of service on or after July 1, 2007. A standardized questionnaire was provided to participants during February 2007 – May 2007. The provider financial statements (July 1, 2006 – December 30, 2006) supporting the cost data were desk reviewed and the rate calculation used the allowable cost data per CMS Provider Reimbursement Manual, submitted by the participating providers. The state calculated a weighted average rate based on cost per unit and added a negotiated 2% allocation for home office (HO) expenses.

2. Mobile Crisis Management (Child and Adult - H2011)

   The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. The service is billed in per 15 minute increments. North Carolina contracted with Technical Assistance Collaborative, Inc. (TAC) to develop a rate methodology for Mobile Crisis Management. The Rate was determined from an analysis of five other states that had a crisis service similar to North Carolina. North Carolina contracted with Technical Assistance Collaborative, Inc. (TAC) to develop and recommend a rate for Diagnostic Assessment (MH/SA) T1023. TAC used National rate data to determine an appropriate rate for this service. The rate information from each state was reviewed for a variety of factors to best match the type of services with those proposed by NC. The services were grouped into the levels of care and service types from NC in order for comparison. Analysis and groupings were based on:

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- Comparability to proposed NC Services,
- Credentials and number of staff providing the services,
- Other program specific requirements such as 24/7 availability, licensure requirements, etc.

Once the comparable and current rates were identified, an adjustment factor was developed for each state to smooth the economic difference between NC and the other states. Factors used were: Cost of Living, Median household income and Community/social service salary levels

The inflation or deflation factors were then averaged to obtain a single factor to apply to the rate from each geographic area to obtain the NC comparable rate. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (vi).

3. Community Support Individual (Adult – H0036HB) (Child – H0036HA)

The rate for these enhanced services was set as of March 20, 2006 and is effective for services on or after that date. The services H0036HB and H0036HA were developed from the blending of existing services Case Management T1017HE and Community Based Services H0036 and H0036HM. However, the actual rate was established based on cost modeling along with input providers. This service is billed in per 15 minute increments where one unit equals 15 minutes. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (iii) and Attachment 3.1-A.1 paragraph 4.b.(8), (c).

The state developed the assumptions used in this calculation by identifying the cost components that support the enhanced service definition. Labor, taxes and benefits necessary to provide the service were identified. The expense for items such as beepers/cell phones, supplies, trainers/materials, and travel were separated from the overhead cost because they are necessary for the direct service deliverable and would not be used for indirect staff. This expense was added at 100%. These specific cost items are not duplicated in the overhead cost.

National Accreditation expense was added at 2% of indirect cost plus direct cost followed by the addition of an 11% indirect overhead cost. The calculation of the 11% overhead rate was derived from the cost data provided by the three participating providers. The calculation of the overhead rate of 11% includes admin payroll, taxes and benefits; travel expenses; facility costs such as utilities, communications, rent/lease, public relations, other services, interest and miscellaneous expenses with applicable adjustments to the provider data where expense was not allowed. Supplies are not included in the 11% calculation.

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To estimate the billable time, the state calculated the reductions to available time (holidays, vacation, sick, and etc.) using provider allowed paid time off as indicated by the providers' data. The cost was divided by the billable units.

3a. Community Support Individual (H0036HA * H0036HB)

The rate for these enhanced services was set as of April 5, 2007 and is effective for services on or after that date, a revised rate was established with input from a Cost Model Work Group, which included 21 providers from across the state as well as state personnel from the Division of Medical Assistance (DMA) and the Division of Mental Health (DMH). The Cost Model Work Group reviewed providers' actual costs, ensuring clinical and treatment qualifications as well as supervision for staff met the Medicaid service definition requirements demanded by the state and by Centers for Medicare and Medicaid Services (CMS). This service is billed in per 15 minute increments where one unit equals 15 minutes. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (iii) and Attachment 3.1-A.1 paragraph 4.b.(8), (c).

The state developed the assumptions used in this calculation by identifying the cost components that support the enhanced service definition. Labor, taxes and benefits necessary to provide the service were identified. The expense for items such as beepers/cell phones, supplies, trainers/materials, and travel were separated from the over head cost because they are necessary for the direct service deliverable and would not be used for indirect staff. This expense is added to the direct staffing cost at 100% to establish the direct cost portion of the program.

All other allowable cost was determined as indirect cost in this model. This does include the Overhead and National Accreditation.

The model is using actual provider cost for the fulltime equivalents required to deliver the service. The state used the actual units reported and made no adjustments for billable units or for productivity. The cost was divided by the billable units.

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3b. Effective October 30, 2008, rates for Community Support Individual (H0036HA and H0036HB) will be paid using a four tier rate methodology that is based upon the different provider qualifications (e.g. Paraprofessional, Associate Professional, Qualified Professional-Unlicensed, and Qualified Professional-Licensed). Payment for Community Support Individual is based on a 15 minute unit of service. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (iii) and Attachment 3.1-A.1 paragraph 4.b(8),(c).

The reimbursement rates are established utilizing cost modeling. Based on input from providers and compared to national data, the cost model recognizes direct care service costs for staff salaries and related fringe benefits, program-related expenses, supervision costs, provider overhead, and productivity.

The cost model based the direct care service costs for staff salaries and related fringe benefits on a compensation survey conducted to determine typical salaries for each tier of provider qualification. These numbers were regionalized through provider input.

Program-related expenses (include supplies, travel and other items that assist the direct care delivery of the program) are allowed at 7% based on an average across all providers.

Facility overhead costs are recognized at 20% of total direct care service costs. The 20% was determined through a market analysis of provider overhead costs and adjusted for reasonable expectations.

Productivity was determined for each of the different provider qualifications utilizing provider input and supported by national studies.

4. Community Support Group (HOO36 HQ)

The rate for this enhanced service was set as of April 5, 2007 and is effective for service on or after that date. A revised rate was established with input from a Cost Model Work Group, which included twenty-one (21) providers from across the state as well as state personnel from the Division of Medical Assistance (DMA) and the Division of Mental Health (DMH). Payment for Community Support Group is based on a 15 minute unit of service. A group is limited to a maximum of eight individuals. The rate change is determined by change in the rate that occurred for Community Support Individual (H0036HA and H0036HB) between the March 20, 2006 rate and the April 5, 2007 rate. Prior to April 5, 2007 the rate for Community Support Group (HOO36 HQ) was determined by the state wide average rate as determined through the 2002 Mental Health Cost Finding with the 13% administrative cost backed out.

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4a. Effective October 30, 2008, the rate for Community Support Group (H 0036 HQ is determined by dividing the rate for Community Support Individual as set in paragraph 3c above by 3.11 to maintain the average group size. Payment for community support is based on a 15 minute unit of service and limited to a maximum of eight individuals.

5. Community Support Team (Adult - H2015HT)

The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. The service H2015 HT was developed from the blending of existing services Case Management T1017HE and Community Based Services H0036HQ, H0036U1 and H0036HM. However, the actual rate was established based on cost modeling along with input from providers. This service is billed in per 15 minute increments where one unit equals 15 minutes. The state developed the assumptions used in this calculation by identifying the cost components that support the enhanced service definition. Labor, Taxes & Benefits necessary to provide the service were identified. The expense for items such as beepers/cell phones, supplies, trainers/materials, and travel were separated from the overhead cost because they are necessary for the direct service deliverable and would not be used for indirect staff. This expense was added at 100%. The cost is not duplicated in the overhead cost. The state added 11% of cost for overhead and calculated this 11% overhead rate using the cost data provided by providers. The calculation of the overhead rate of 11% includes admin payroll, taxes and benefits; travel expenses; facility costs such as utilities, communications, rent/lease, public relations, other services, interest and miscellaneous expenses with applicable adjustments to the provider data where expense was not allowed. Supplies are not included. To estimate the billable time, the state calculated the reductions to available time (holidays, vacation, sick, and etc.) using provider allowed paid time off as indicated in the model. The cost of national accreditation was included in this rate development outside of all other expense. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (vii).

6. Mental Health Day Treatment (Child – H2012HA)

The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. The state started the rate development with the existing service Day Treatment - Child H2012HA and added 2 hours of Case Management from T1017HE and 1.5 hours of Family Therapy H0004 to develop the enhanced Child and Adolescent Day Treatment H2012HA. Assumption is that billing of H2012HA will be for 8 hours per day for 4 days a week. This service is billed in hourly increments and is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (vii).

The initial rate for Child and Adolescent Day Treatment H2012HA was based on the 2001 Mental Health Cost Finding rate for Y2311 of $5.23 per 15 minutes multiplied by 4 (hourly unit rate of $20.92) less the 13% administrative cost allowed AMH Programs (20.92*.87) for a rate of 18.20 per hour.

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Two hours of Case Management were added in from T1017HE at $22.65 per 15 minutes. This $22.65 was calculated using the 2002 Mental Health Cost finding reports submitted by the AMH Programs. The 13% administrative cost allowed AMH Programs was backed out ($22.65*.87) for a rate of $20.23 per 15 minutes. This $20.23 was inflated forward four years to calculate the $22.66 per 15 minute rate. To determine the amount to add to the enhanced service multiply 22.66 * 8 (2 hours) and divide by 24 (6 hrs per day for 4 days per week).

The 1.5 hours of Family Therapy H0004 were added in from H0004 at $22.00 per 15 minutes. This $22.00 was calculated using the 2002 Mental Health Cost finding reports submitted by the AMH Programs. The 13% administrative cost allowed to AMH Programs was backed out ($25.29*.87) to get $22.00per 15 min. No inflation was added. To determine the amount to add to the enhanced service multiply 22.00 * 6 (1.5 hours) and divide by 24 (6 hrs per day for 4 days per week).

7. Multi Systemic Therapy (Child – H2033)

The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. This service is billed in per 15 minute increments. This rate was developed through modeling by Technical Assistance Collaborative, Inc. (TAC) along with input from providers. The rate was developed from the salary and benefits of the professionals providing the service and was modeled using NC assumptions on service delivery. The rate was established by dividing the total annual program cost by the total annual hours to get an hourly cost that was then reduced to the 15 minute billable unit. This service is provided in accordance with Attachment 3.1-A.1, paragraph 4.b. (8)(h).

8. Ambulatory Detoxification (Child and Adult - H0014)

The rate for this enhanced service was set as of June 1, 2006 and is effective for services on or after that date. This rate is based on cost modeling along with input from providers and the rate was developed from the salary and benefits of the professionals providing the service. This service is billed in per 15 minute increments. The monthly rate is determined by multiplying the number of staff required times the annual salary for the type of professional performing the task divided by 12 months. The monthly rate is then divided by the expected 1000-15 minute units (Amount of Staff x (Full Salary / 12 months)/ (1000 units) (Unit = 15 minutes). This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (xv).

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9. Professional Treatment Services in Facility Based Crisis Programs (Adult – S9484)

The rate for this enhanced service was set as of March 20, 2006 and is effective for services on or after that date. The rate for S9484 was derived from the existing rate for Crisis Intervention S9485 (per diem limited to 15 consecutive days; paid per day). The cost per unit for existing service, S9485, was set using the 2002 Mental Health Cost Finding data submitted by the AMH Programs. The 13% administrative overhead was backed out and the rate was inflated forward three years. DMA used this existing daily rate and divided by 16 hours to get the hourly billing rate for S9484. This service is provided in accordance with Attachment 3.1-A.1, paragraph 13 C (ix).

The facilities providing these services are not IMD facilities.